**PENSIONS**
INVESTMENTS
LIFE INSURANCE

Irish Life

# COMPANY PENSION LIFE INSURANCE
## APPLICATION DETAILS

**Before you give us your personal information please note that Irish Life has a Data Privacy Notice. This explains what your data protection rights are and how and why we use your personal information. This is always available on our website at www.irishlife.ie or you can ask us for a copy.**

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.

If any item is blank or illegible, this will cause a delay in processing your application.

000008

## Financial Adviser Details

Financial Adviser Name

Financial Adviser Code

**If your Financial Broker or Adviser submits your application electronically Irish Life will only receive a copy of the Declarations section of this form. The original application form will be retained by your Financial Broker of Adviser and not checked by Irish Life.**

## 1. Personal Details

Title (Mr/Mrs/Ms etc)

First Name

Surname

Date of Birth (dd/mm/yyyy) / /  Age Next Birthday

Gender  Male ◯  Female ◯

Relationship Status  Single ◯  Married ◯  Widowed ◯  Separated ◯  Divorced ◯  Registered Civil Partner ◯

Country of Birth

During the last 12 months, which of the following best describes your smoking habits:

A Non-smoker has not smoked or used any nicotine replacement products or E-cigarettes in the last [illegible] months

Smoker ◯  Occasional smoker ◯  Used nicotine replacement products or E-cigarettes ◯  Non Smoker ◯

Previous Surname (if any)

Occupation

Chosen retirement age must be between 60 and 70

Chosen Retirement Age

We need this information to ensure that the level of cover suits your circumstances

Level of Earnings  € each year

PPS Number  -

We require your PPSN to obtain approval from the Revenue Commissioners

Address

Mobile Number

Home/Work Number

Email

## 2. Employer Details

Name of employer

Company registered number

Address for correspondence

Employer contact name

Employer contact phone number

## 3. Revenue Information

Address of the registered office of the employer

Does the employee have other pension benefits from previous/current employments? Yes ◯ No ◯

**If YES, please complete the Previous Pension details in CAB**

Please give plan numbers of any existing Irish Life Pension contracts in respect of this employee

Employee's tax district

Employer's tax district

Employer's PRSI Number -

If Yes, please complete the Politically Exposed Person (PEP) or Relative or Close Associate (RCA) Supplementary Form An explanation of these terms is provided in Supplementary Form

## 4. Politically Exposed Person (PEP) or Relative or Close Associate (RCA) of a PEP

Are you or any of the Beneficiaries, Trustees, Settlors, Appointers or in the case of a Company Owner, Director, Beneficial Owner (or have been within the last 12 months), a PEP or RCA ? Yes ◯ No ◯

At any time up to the end of the term, you have the option to convert to another life cover plan. The exact definition and terms available in the olicy document. The option of Guaranteed Life Cover again only applies to a maximum Life Cover of €1 million. These limits are in respect of the total cover converted across all policies belonging to the life assured.

If not please let us know later when you want cover to start

## 5. Company Pension Term Assurance

Amount of Life Cover you want €

Age at which cover should cease

Do you want inflation protection? Yes ◯ No ◯

Do you want Guaranteed Cover again (convertible option)? Yes ◯ No ◯

Is the cover to start immediately? Yes ◯ No ◯

## 6. Payment Details

Premium amount €

Frequency of Direct Debit Every Month ◯ Every 3 Months ◯ Every 6 Months ◯ Every Year ◯

1st to 28th of month

What date of the month do you want your Direct Debit taken? ☐☐

Cheques for regular contributions can only be made when contributions are made on a yearly basis and exceed €600 ◯

If NO we will contact your financial adviser for confirmation of the start date

Do you want your cover to begin immediately, if accepted? Yes ◯ No ◯

## 7. Communications and Transactions

If you do not choose an option we will assume you want to receive communications by paper post. Your Plan communication will be securely stored in your personal online account at www.irishlife.ie. You will be notified by text and email when communications are added to your account.

How would you like to receive your plan communications from us? (for example, your welcome pack, letters and regular statements). Please tick one option:

◯ Online ◯ By Paper Post

Plan Schedule by post everything else electronically Yes ◯ No ◯

Would you like the original plan schedule to be sent to the adviser? Yes ◯ No ◯

Is the plan being set up under a conversion of an existing Irish Life Plan? Yes ◯ No ◯

Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1. **T**: 01 704 1010 • **F**: 01 704 1900

Irish Life

# UNDERWRITING QUESTIONS

**PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.**
If any item is blank or illegible, this will cause a delay in processing your application.

## Medical and Other Information

**Your personal health information:**

In addition to our Irish Life Data Privacy Notice, the following is more detail relating to your personal health information that we collect and use in connection with this plan contract.

We need your relevant personal information and personal health information for underwriting decisions. This will determine whether we can offer cover and on what terms. We also need your relevant personal information and personal health information to assess and pay claims. If relevant, we will share your personal health information with reinsurers for underwriting and claims decisions. We can use your personal information and personal health information for any subsequent applications to Irish Life.

In addition to the personal health information we collect from you, we will request and receive your relevant personal health information from GPs, consultants, hospitals or other health professionals, and share your relevant personal health information with GPs, consultants, hospitals or other health professionals, if needed.

**Material Facts:**

You must tell us all relevant information when answering all of the questions. If you do not, or if any answers are not true and complete, we could treat the plan as void. This includes disclosing tobacco consumption or use of nicotine replacement products including e-cigarettes. If you fail to reveal all material facts there will be no cover under the plan, we will not refund the payments and we will not pay a claim.

A material fact (relevant information) includes anything that would likely influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the section 'Other medical evidence'. We may also contact you if we need to ask you for further information on your answers or as part of any subsequent claim. We will rely on what you tell us and we will not automatically clarify or confirm any information you provide.

You can address any highly confidential information to Irish Life's Underwriting Team in a sealed envelope with your name, date of birth and application number (if applicable). You must refer to this information when answering your health questions.

If your health, circumstances, or answers to any of the questions in this application form change between the date you apply for cover and the date your application is accepted, you must let us know immediately as failure to do this may result in a claim being refused.

**Genetic Test Information:**

You should not tell us about any genetic test (that is, any analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. You must however, tell us if you are having treatment for, or experiencing symptoms of, a genetic condition. You will be asked for full information about your family history, including all genetic conditions.

**Consent to Automated Decisions, including Profiling:**

I agree to automated underwriting decisions being made about me based on set risk criteria and using my personal information, including personal health information. I understand this will make my application process quicker and that the automation is designed to reduce costs, improve efficiency, quality and consistency in underwriting decisions. I understand that I have the right to withdraw consent at any time by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. I also understand that I have the right to object and to request that a person review and make the final underwriting decision.

| | | |
|---|---|---|
| Life Assured 1 | I agree ◯ | I don't agree ◯ |
| Life Assured 2 | I agree ◯ | I don't agree ◯ |

## Medical and Other Information *(continued)...*

| | First Person | Second Person |
|---|---|---|
| (1). Please give the name and address of your doctor. | | |
| If you have changed doctor in the last year, please give the name and address of your previous doctor as well. | | |

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**(2). Please give your height and weight**

| First Person | | Second Person | |
|---|---|---|---|
| ☐ Feet | ☐ Inches | ☐ Feet | ☐ Inches |
| ☐ Stones | ☐ lbs | ☐ Stones | ☐ lbs |
| OR | | OR | |
| ☐ Cms | | ☐ Cms | |
| ☐ Kg | | ☐ Kg | |

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**(3). Which of the following best describes your smoking habits:**

Please specify what do you smoke and how many / much a day below

A Non-smoker has not smoked or used any nicotine replacement products or E-cigarettes in the last 12 months

It is our practice to carry out occasional tests to confirm smoker status

| | First Person | Second Person |
|---|---|---|
| I am a smoker | ◯ | ◯ |
| I am an occasional smoker or have smoked in the last 12 months | ◯ | ◯ |
| I have used nicotine replacement products including E-cigarettes in the last 12 months | ◯ | ◯ |
| I have not smoked or used nicotine replacement products including E-cigarettes in the last 12 months | ◯ | ◯ |
| I am a life long non smoker | ◯ | ◯ |

**If selected 'I am a smoker':**
What do you smoke and how many/ much a day?

| | First Person | | Second Person | |
|---|---|---|---|---|
| | | **number** | | **number** |
| Cigarettes | ◯ | ☐ per day | ◯ | ☐ per day |
| Cigars | ◯ | ☐ per day | ◯ | ☐ per day |
| Pipe | ◯ | ☐ per day | ◯ | ☐ per day |

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**(4). Typically, how many alcoholic drinks do you consume in a week?**

One alcoholic drink is: a pint of beer, a glass of wine or one measure of spirits.

| | First Person | Second Person |
|---|---|---|
| None | ◯ | ◯ |
| 1 - 10 | ◯ | ◯ |
| 11 - 20 | ◯ | ◯ |
| 20 - 40 | ◯ | ◯ |
| 40 - 60 | ◯ | ◯ |
| Over 60 | ◯ | ◯ |

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**(5). Have you ever had treatment or advice from a health professional in relation to stopping or reducing your alcohol consumption?**

| First Person | | Second Person | |
|---|---|---|---|
| Yes ◯ | No ◯ | Yes ◯ | No ◯ |

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Diabetes includes Type 2 diabetes treated by diet, gestational diabetes or Sugar in urine

**(6). Have you ever had diabetes (type 1 or 2 or pregnancy related) or sugar in the urine?**

| First Person | | Second Person | |
|---|---|---|---|
| Yes ◯ | No ◯ | Yes ◯ | No ◯ |

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## Medical and Other Information *(continued)...*

| | First Person | | Second Person | |
|---|---|---|---|---|
| (7). Have you ever had any disease or disorder of the heart, including angina, heart attack, bypass, cardiomyopathy, heart valve disorder or heart murmur? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (8). Have you ever had a stroke, brain haemorrhage or brain injury, transient ischaemic attack(TIA), aneurysm, or any disease of the arteries or veins, including poor circulation in the legs? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (9). Have you ever had treatment or advice for any form of cancer or malignant condition, leukaemia, Hodgkins disease, lymphoma, melanoma, or a benign brain or spinal tumour? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (10). Have you ever had symptoms of or had treatment for epilepsy (including seizures, fits or blackouts), multiple sclerosis, optic neuritis, paralysis or any neurological condition? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (11). Have you ever had symptoms of, treatment or investigations for trembling, numbness, loss of feeling or tingling in face, hands or feet or temporary loss of muscle power? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (12). Have you ever had symptoms of or treatment for any disorder of the stomach, liver, pancreas or bowel (including Crohn's disease, ulcerative colitis, polyps or ulcer)? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (13). Have you ever had symptoms, treatment or advice for or been referred for any mental health problems including depression, self harm or psychiatric disorders including bipolar, mood or eating disorders? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (14). Have you ever taken drugs for other than medicinal purposes, including the use of recreational drugs? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (15). Have you ever tested positive for Hepatitis B or Hepatitis C, HIV or are you waiting for the results of such tests? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (16). Are you currently taking or have you been advised to take prescribed drugs, medicines or tablets, creams, inhalers, drops or sprays or have you taken such a course lasting more than two weeks within the past year? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (17). Within the past five years have you been diagnosed with or had treatment for high blood pressure, high cholesterol, chest pains, an irregular heart beat or any blood disorder including haemochromatosis or anaemia? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (18). Within the past five years have you had symptoms or had treatment for asthma, bronchitis, sarcoidosis, emphysema or any other disorder of the lungs or airways? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (19). Within the past five years have you noticed or had symptoms, treatment or advice for any cyst or lump including breast lump or cyst, an abnormal cervical smear, an abnormal mole or a growth whether seen by a doctor or not? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (20). Within the past five years have you had symptoms of or treatment for any kidney, bladder, urinary disorder (including blood/protein in urine) or prostate disorder (including raised PSA level)? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (21). Within the past five years have you had any symptoms of or treatment for any disorder of eyes (including any visual disturbance of the eyes, such as double vision or blurred vision) or the ears (including hearing impairiment or loss of balance)? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |

Vision corrected by lens can be ommitted

## Medical and Other Information *(continued)...*

| | First Person | | Second Person | |
|---|---|---|---|---|
| (22). Within the past five years have you had any symptoms of, or required treatment for:<br>• any back or neck pain including sciatica, trapped nerves or whiplash<br>• any joint pain or disorder of the knees, hips, ankles, shoulders, elbows or wrists<br>• any type of arthritis or gout<br>• any muscular pains, cartilage, ligament or tendon injuries? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (23). Within the past five years have you had any symptoms, treatment or advice for stress, anxiety, low mood, chronic fatigue or fibromyalgia? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (24). Within the past five years, have you seen or been advised to see any specialist as an in-patient or out-patient at any hospital or clinic for any other illness or condition not already mentioned? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (25). Within the past five years have you undergone or been advised to undergo any medical investigation including blood test, scan, imaging and x-ray or to have a surgical operation? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (26). Within the past three years have you been unable to work for more than four consecutive weeks at a time? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (27). Do you take part in or have any intention of taking part in any kind of hazardous leisure activity (including private flying, motor sports, mountaineering or scuba diving etc)? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (28). Have you any intention of living or travelling outside of the EU, other than for holidays of less than 8 weeks duration, or have you resided out of the EU, North America, Australia or New Zealand for longer than one year in the last 10 years? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (29). Have you ever been offered specical terms, postponed or declined for life cover, income protection or specified illness cover or have you made a claim for income protection or specified illness cover? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| (30). Have any of your parents, brothers or sisters ever had any of the following conditions before age 60? | Yes ◯ | No ◯ | Yes ◯ | No ◯ |

Failure to disclose a family history could result in a potential claim being refused.

*Angina - Heart Attack - Bypass surgery - Angioplasty - Cardiomyopathy - Stroke - Diabetes - Cancer (Bowel, Breast, Ovarian or other site) - Familial Polyposis of the Colon - Polycystic Kidneys - Multiple Sclerosis - Motor Neurone Disease - Parkinson's - Alzheimer's - Dementia - Muscular Dystrophy - Huntington's.*

| | First Person | | Second Person | |
|---|---|---|---|---|
| | Condition Suffered | Age Started | Condition Suffered | Age Started |
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| Sisters | | | | |

## Medical Details – Other Medical Evidence

**Is there any other medical evidence you would like to disclose in relation to the health questions above?**

**First Person**

Question No

**Second Person**

Question No

| | First Person | Second Person |
|---|---|---|
| Will there be a Fast Track Questionnaire or any other questionnaires accompanying the application form? | Yes ◯ No ◯ | Yes ◯ No ◯ |

Information is correct as of 01/05/2018 and is subject to change.

Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1. **T**: 01 704 1010 • **F**: 01 704 1900

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# COMPANY PENSION LIFE INSURANCE PLAN
## DECLARATIONS

**Proposal Number:**

We need this information to match the declaration section to your electronic application

Customer Review Number

Customer Name

Financial Adviser Name

**If you submit this proposal electronically you should only send us this section.**

**Any words in the singular also mean the plural as applicable (e.g. "I" means "we" and "my" means "our" etc.)**

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## A. Letter of Exchange

**By completing the Letter of Exchange the employer sets the pension scheme up in trust for the employee.**

Between

**("the employer")**

And

**("the employee")**

Date d d / m m / y y y y

**Dear Employee**

The employer has decided to offer you the advantages of a Company Pension Life Insurance Plan *(hereinafter called "the Plan")*.

The Plan commences on the date of this letter ("the commencing date"), and is governed by this letter and the Rules of the Scheme ("the Rules"), a copy of which you will receive.

The Employer establishes the Plan under irrevocable trusts to be administered in accordance with the Rules. This retirement benefits scheme is capable of being treated by the Revenue Commissioners as an exempt approved scheme in accordance with Chapter 1 of Part 30 of the Taxes Consolidation Act 1997 to provide you, the employee, with the relevant benefits as defined therein.

The Plan is an occupational pension scheme and a defined contribution scheme within the meaning of the Pensions Act 1990 and this letter and the Rules shall be construed subject to the provisions of the said Act.

The Scheme is established as a one member arrangement within the meaning of the Occupational Pension Schemes (Investment) Regulations 2006 to 2010 and the Occupational Pension Schemes (Disclosure of Information) Regulations 2006 to 2013. While you have discretion to give instructions as to the investment of scheme resources in accordance with the Rules, the Life Office is not responsible for any instructions you give to the Employer or the Trustee which are not received by the Life Office.

The Plan benefits will be provided by means of an assurance or assurances, under a policy or policies to be issued by Irish Life Assurance plc ("the Life Office") in pursuance of the Application to which this letter is attached and of any subsequent supplementary applications made to the Life Office ("the Applications").

The employer hereby selects and appoints the trustee named above as trustee of the Plan.

The trustee will own and is entitled to receive all information on the policy or policies issued by the Life Office in relation to the Scheme. The employer and employee understand and acknowledge that the trustee will process and hold this information for the purposes of issuing and administering all aspects of this contract, including disclosing the data to regulatory authorities, or, as required by law.

The contributions payable towards the assurance or assurances will be contributions made by you (including Additional Voluntary Contributions) and/or the Employer in accordance with the Applications subject always to the Rules.

Please acknowledge receipt of this letter by signing below and returning it to the employer.


Please sign and date

Signature of person duly authorised to sign for and on behalf of the **EMPLOYER**. ✗

Name of authorised person

Position in company

I acknowledge receipt of this letter and understand the contents hereof. I hereby agree to be included in the scheme.


Please sign and date

Signed **EMPLOYEE** ✗

## B. Revenue Details

Details are required as part of the approval process with the Revenue Commissioners. If there is insufficient space below please attach additional details on a separate sheet.

**Does the employee have any pension benefits from current or previous employments**
(this information must also be provided where retirement benefits have already been taken)? Yes ◯ No ◯

If NO, please go to section C.

If Yes, please complete the rest of this section.

**1. Does the employee have Defined Contribution company scheme pension benefits from current or previous employments?**

Yes - Current employment ◯ Yes - Previous employment ◯ No ◯

**If Yes to either provide details:**

Normal retirement age

Current value (Including AVC / PRSA AVC values) €

**If current employment**

Total employer contributions € per annum

Total employee contributions € per annum

Name of Life Office

**If previous employment**

Scheme Name

Name of Life Office

**2. Does the employee have Personal Pension/PRSA (including self-employed) pension benefits from current or previous employments?**

Yes ◯ No ◯

**If Yes provide details** Current value €

Name of Life Office

**3. Does the employee have Defined Benefit Company scheme pension benefits from current or previous employments?**

Yes - Current employment ◯ Yes - Previous employment ◯ No ◯

**If Yes to either provide details**

| Normal retirement age | Employee pension payable at NRA | Retirement lump sum (if in addition to pension at NRA) | Spouses pension % / Registered civil partners pension % |
|---|---|---|---|
| | € | € | |

Current value of any AVC / PRSA AVC € 

**If current employment** Total employee & AVC contributions € per annum

Death benefit €

Name of Life Office

**If previous employment** Date of leaving service d d / m m / y y y y

Scheme Name

Name of Life Office

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**4. Have you received retirement benefits from any other pension arrangements?** Yes ◯ No ◯

**If Yes provide details**

Date benefits were paid? d d / m m / y y y y

**For Defined Contribution Schemes, PRSA or Personal Pension benefits:**

Total value of pension fund at date of payment €

**For Defined Benefit / Public Sector Schemes:**

Gross Retirement Lump Sum (before any tax paid): €

Annual pension income: € a year

Final value of AVCs (if not included in the above amounts): €

Further pension benefit details (if any)

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## C. Employee/Member Plan Declaration

I understand and agree that the contract proposed with Irish Life Assurance plc (Irish Life) will be based on this application form (online or otherwise), Letter of Exchange in this application form, any supplementary questions answered, any statements made to Irish Life in writing or by telephone, any information I give to a medical examiner acting for Irish Life and all terms and conditions given to me by Irish Life.

I have read and understand the important information about my obligation to tell Irish Life about all material facts in connection with the application and I understand that if I do not tell Irish Life all material facts, this contract could be void. If this happens, I understand and acknowledge there will be no cover under the plan, Irish Life will not refund my premiums and Irish Life will not pay a claim.

I declare that all information, statements and answers I have provided, including those about tobacco consumption or use of nicotine replacement products including e-cigarettes, are true and complete.

I understand that I must tell Irish Life in writing about any changes in my health, circumstances, or answers to the questions in this application form change between the time I applied for cover and the date my application is accepted.

I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment. I acknowledge that a copy of my application will be sent to me and agree to notify Irish Life, in writing, if:

- I do not receive the printed record
- Any information in this record is, false, incorrect or incomplete

I understand that Irish Life can use my personal information for any subsequent applications to Irish Life.

I authorise Irish Life to request and receive my personal health information now (or as part of any claim assessment including after my death) from any health professional who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of processing my application and assessing claims.

- I declare that I have been provided with the necessary information to make an informed investment decision. I am happy with the investment choice made on this application form (or supplied though any additional documents linked to this application).
- I confirm I have read and understood the Medical and Other Important Information section.
- I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.
- I confirm I have read and understood the Plan Declaration

Please sign and date

Signature ✗

Date d d / m m / y y y y

## D. **Employer Declaration To Irish Life** - must be completed in all cases where the employer is the trustee or where an independent trustee has been appointed.

I declare that all the answers to the above questions are in every respect true and correct. I hereby agree that the contract proposed with Irish Life Assurance plc (Irish Life) will be based on the declarations and Letter of Exchange in this application form (including this declaration), together with all terms and conditions furnished by Irish Life. I declare I know of no material fact other than those stated, being a fact concerning circumstances which may influence the assessment and acceptance of an application by Irish Life.

I understand that failure to disclose all material facts could render the contract void. I understand that if I am in doubt as to whether any facts are material I should disclose them.

I understand that the product(s) are conditional on the approval of the arrangement by the Revenue Commissioners as an exempt approved scheme under Chapter 1 of Part 30 of the Taxes Consolidation Act 1997.

I acknowledge and I understand and accept that the contract to which this application form and declaration applies is between Irish Life and the parties named on the Letter of Exchange that established this scheme. I confirm that the contract effected in pursuance of this application will be held by the Trustee under irrevocable trust for the purpose of providing retirement and other relevant benefits as defined by Chapter 1, Part 30 of the Taxes Consolidation Act 1997 to or in respect of the employee as set out in the Rules of the Scheme. Irish Life will act on either my (the employer's), the employee's or the trustee's instructions in accordance with the Plan's Terms and Conditions.

S59 of Part VI of the Pensions Act, 1990 as amended, requires that a registered administrator is appointed and I understand that Irish Life are appointed to act as such for this Scheme. By accepting this application, Irish Life agrees to act in accordance with this role (outlined in S64G of Part VIA of the Act). I agree that either Irish Life or the trustee can choose to terminate this appointment by giving at least 90 days written notice to the other party. This 90 day notice period may only be reduced where both parties agree to it, or if required by legislation.

If the employer named on the Letter of Exchange is also appointed as Trustee I acknowledge that I as the trustee am responsible for ensuring that the employee (member) has been/will be provided with all information required by relevant pension's legislate on and all information necessary to enable him/her to exercise any discretion allowed under the Scheme Rules in relation to investment choice.

I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.

Please sign and date

Signature ✗

Duly authorised to sign for and on behalf of the Employer, and as Trustee if relevant

Date d d / m m / y y y y

## E. Optional Consent

**Consent to Sharing with Other Companies in the Irish Life Group**

I agree to Irish Life Assurance sharing my personal information (excluding my personal health information) with other companies within the Irish Life Group, such as Irish Life Health. I understand this is to assist in developing combined customer services (for example, access to services from different Group companies on one online platform). This is an area that will continue to improve with a view to adding new customer engagement offerings.

You can change your mind at any time and opt-out of any further sharing by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. If you opt-out we will keep a record of your instruction to opt-out.

| | | |
|---|---|---|
| Customer | I agree ○ | I don't agree ○ |
| Trustee | I agree ○ | I don't agree ○ |

Irish Life

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## Your Irish Life Plan Details

**Please complete <u>all</u> the fields in this Section**

Plan Number(s)

If this mandate is to cover more than 3 plans, please attach separate instructions.

Name of Plan Owner(s)

Direct Debit collection date ____ of the month (1st to 28th only)

Payment frequency Monthly ◯ Quarterly ◯ Half Yearly ◯ Yearly ◯

# SEPA DIRECT DEBIT MANDATE

**Please complete all the fields below marked * and return this mandate to Irish Life**

## Name and address of the payer:

* Name(s) of Account Holder(s)

Address of Account Holder(s)

BIC

* IBAN

Your BIC and IBAN can be found on a recent bank statement

Please sign and date

* Signature(s) ✗

✗

* Date of signing d d / m m / y y y y

By signing this mandate form, you authorise (A) Irish Life to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Irish Life. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

## For Office Use only

UMR

Creditor Identifier IE30ZZZ303587

Type of payment Recurrent ✔

Creditor's name and address

IRISH LIFE ASSURANCE PLC
LOWER ABBEY STREET
DUBLIN 1